

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-037500

STATE FILE NUMBER

DO NOT WRITE
ON THIS SUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 331

FILED OCT 29 1962

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
Length of stay in 1b <u>life</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kirksville Osteopathic</u>		d. STREET ADDRESS (If outside, give location) <u>315 S. Cottage Grove</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <u>Iris</u> Middle <u>Ilene</u> Last <u>Yowell</u>	4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1962</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1919</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Ward</u>	11. BIRTHPLACE (City and state or country) <u>Adair Co, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Leonard Douglas</u>	13b. MOTHER'S MAIDEN NAME <u>Maudie Darr</u>	14. NAME OF HUSBAND OR WIFE <u>Dental Yowell</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Dental Yowell Kirksville, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Operative Shunt + Hemorrhage</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
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DUE TO (c) <u>Toxemia and Obstruction + Gangrene of Ileum 1 week</u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from <u>Sept Oct 22, 1961</u> to <u>Oct. 22, 1962</u> and last saw her alive on <u>Oct. 22, 1962</u> Death occurred at <u>3:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James F. Gipe</u>	(Degree or title) <u>D.O.</u>	22b. ADDRESS <u>EDW. Jeffers, Kirksville, Mo</u>	22c. DATE SIGNED <u>10-23-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-25-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hills Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kirksville Missouri</u>
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24. FUNERAL DIRECTOR <u>Dee Riley Funeral Home, Inc.</u>	ADDRESS <u>415 North Franklin</u>	25. DATE RECD. BY LOCAL REG. <u>10-25-1962</u>	26. REGISTRAR'S SIGNATURE <u>James W. Ratliff</u>
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Kirksville, Missouri

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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Permit renewed Oct 25, 1962

JAMES F. GIPPE, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Larry Jackson

Licensed Embalmer No. 5158

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.